MULTIPLE EMPLOYER TRUST FILING

Ref: Section Ins 6.62, Wis. Adm. Code

State of Wisconsin
Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873
(608) 266-3585

INSTRUCTIONS: Return this form with all other required material to the above address. These items must be submitted before soliciting, advertising, marketing, or accepting an application for or placing coverage of a person with a multiple employer trust (MET) or association as defined in s. Ins 6.62, Wis. Adm. Code. If any change occurs, this form must be refiled with the corrected information within 15 days of the date the change is effective.

Name of Person/Organization Making the Filing		Phone Number ( )	
Address	City	State	Zip Code
(Check One) ☐ Multiple Employer Trust or Association ☐ Intermediary			

I certify that the items checked below and the attachments are true and correct and satisfy the requirements of s. Ins 6.62, Wis. Adm. Code.

☐ A complete and accurate copy of the insurance policy or contract which is in effect and covers benefits or coverage offered by the MET or association is attached.

☐ Name, address, phone number, and domiciliary state of insurer issuing the insurance policy or contract indicated above.

A complete and accurate copy of the organizational documents of the MET or association are attached.

☐ Articles of Incorporation

☐ Bylaws

☐ Trust Instrument, including names and addresses of trustees

☐ Other—Please specify _____

_____

The benefits or coverage offered by the MET or association are (check one)

☐ Fully Insured

☐ Are Not Fully Insured (attach explanation)

Title of Officer (MET only)	Name of Officer or Intermediary (Please Print)
Date	Signature of Officer or Intermediary

False statements on this form and on items attached to this form are in violation of s. 628.34 (1), Wis. Stat. An intermediary or officer who certifies a false statement is subject to criminal and civil penalties.